

**Instructions for completing "The Application for Maine Camp License Renewal" form:**

A temporary Camp License entitles the holder to care only for patients at the particular camp at which he/she is employed.

1. Please type or print clearly in ink.
2. Answer all questions completely and clearly.
3. Provide complete address of current hospital affiliation.
4. Provide a notarized photocopy of a current, active, unrestricted medical license from another state/province. **The copy of current license must be notarized with the following statement:**

**"I certify that I have seen the original and this is a true copy of same."**

5. Submit the completed application together with all supporting documents and the NON-REFUNDABLE fee of \$100.00 to the Board of Licensure in Medicine **at least thirty days prior to the desired effective date of licensure.**

**6. Malpractice Claims:**

Your insurance carrier or attorney must provide an independent detailed explanation of all malpractice claims. This information must be received directly from the insurance company or attorney. This information is in addition to your personal explanation. Application form items 5.13 & 5.14, regarding professional (malpractice) liability claims experience, are the questions most likely to generate follow-up letters from the Board staff and delay your licensure if not answered completely. Report all claims of which you have been noticed, as well as all claims from which you were dismissed as a defendant or for which your insurance company made a settlement of any kind with the plaintiff, or any claim for which a court found you liable in any degree. A reporting form is provided at page 11. Claims against a professional corporation are considered a claim against the individual licensee who provided the professional services in dispute. To be complete, your supplemental explanation must include, for each such claim reported, a full description using the Professional (Malpractice) Liability Claims Experience Form attached (Page 12). See the following fictitious example:

Identity of Case: Burns v. John B. Doe, MD, Samuel E. Smith, MD, Topeka Woman's Hospital, Inc. et al.; Kansas Third Circuit Court, Topeka, Case #89-10203

Date/Place of Original Occurrence: June 4, 1990, Topeka Woman's Hospital

Malpractice Alleged by Claimant: Delayed diagnosis of ectopic pregnancy.

Summary of my Defense: I was a PGY II resident at the time. Dr. Samuel E. Smith, Chief of Obstetrics, Topeka Woman's Hospital was attending physician in this case. I was named in the claim because my name appears in the chart as the physician ordering ultrasonography on first hospital day.

Current Status of Case: Although a motion to dismiss me as a defendant is pending, my insurance company has offered a settlement on my behalf of \$15,000.00 on February 14, 1992. I have been told the plaintiff rejected this and the claim is still pending.

Name and Address of Insurance Company/Attorney Defending Case: Great Plains Physicians' Mutual Indemnity, Attn: Jim Brown, Claims Manager, 4321 Ketcham Blvd., Rock Springs, SD 79104. I am also represented by William B. Eagle, Eagle, Hare, P.A., 44 West River Drive, Suite 200, Topeka, KS 60301.

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**Please Note:**

**Mandated Reporter Requirements for Suspected Child Abuse**

Maine law requires that physicians immediately report or cause a report to be made to the Maine Department of Health and Human Services (DHHS) when the physician knows or has reasonable cause to suspect that a child has been or is likely to be abused or neglected or that a suspicious child death has occurred. **In addition, Maine law requires physicians to immediately report to the Maine DHHS if a child is under 6 months of age or otherwise non ambulatory exhibits evidence of the following: Fracture of a bone; Substantial bruising or multiple bruising; Subdural hematoma; Burns; Poisoning; or Injury resulting in substantial bleeding, soft tissue swelling or impairment of an organ.**

**Mandated Reporter Training and additional information regarding mandated reporting can be found at:**

<http://www.maine.gov/dhhs/ocfs/cps/>

**Maine Prescription Monitoring Program**

As of August 1, 2014, Maine law requires all Allopathic Physicians, Osteopathic Physicians, Dentists, Physician Assistants, Podiatrists, and Advanced Practice Registered Nurses who are licensed to prescribe scheduled medications to register with the Prescription Monitoring Program (PMP). To register, please go to the Prescription Monitoring Program website: <http://www.maine.gov/pmp> Download, complete and sign a registration form located within the yellow box. You may mail, scan and email or fax a signed form to the information located on the form. Please note there are two types of registration forms available, 1) Data Requester form for active prescribers with a DEA number and, 2) Sub-Account form for assistants/non-prescribing health professionals.

More PMP information is available at: <http://www.maine.gov/dhhs/samhs/osa/data/pmp/prescriber.htm>

**The Board strongly recommends regular use of the PMP**

The Board's staff is available to assist you by phone at (207)287-3782, Monday through Friday, 8:00 am to 4:30 pm, Eastern Daylight time.

**RETURNING  
CAMP  
PHYSICIANS  
ONLY**

**STATE OF MAINE  
BOARD OF LICENSURE IN MEDICINE**

137 State House Station  
Augusta, Maine 04333-0137  
(207) 287-3602

Fee: \_\_\_\_\_

**APPLICATION FOR LICENSE TO  
PRACTICE MEDICINE AND SURGERY**

At Camp \_\_\_\_\_  
Address: \_\_\_\_\_  
\_\_\_\_\_, ME. \_\_\_\_\_  
Camp Telephone (\_\_\_\_) \_\_\_\_\_

Date From: \_\_\_\_\_  
Date To: \_\_\_\_\_

Name \_\_\_\_\_  
Last First Middle Social Security Number

Address \_\_\_\_\_ Birthplace \_\_\_\_\_  
City State  
Birthdate \_\_\_\_\_  
Month Day Year

Daytime Telephone (\_\_\_\_) \_\_\_\_\_ Email Address \_\_\_\_\_

Current Hospital Affiliation \_\_\_\_\_  
Name Complete Address

Current State License \_\_\_\_\_  
State License Number Status Expiration

**AFFIDAVIT**

I, \_\_\_\_\_, being duly sworn, depose and say that I am the person described and identified and that all statements made by me herein are true and correct.

\_\_\_\_\_  
Signature of Applicant Date

Subscribed and sworn to me this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_

Notary Public for \_\_\_\_\_  
Signature of Notary

My commission expires: \_\_\_\_\_

## PERSONAL DATA

Check off (X) each appropriate response. Every 'YES' response must be fully explained by written statement on a separate 8.5" x 11" sheet of white paper. Each such explanation must be cross-referenced with the question number, and must be signed, dated, and enclosed with your application.

**NOTE TO MD/APPLICANT: PLEASE COMPLETE THIS FORM YOURSELF – DO NOT DELEGATE ITS COMPLETION.**

**HAVE YOU EVER:**

**YES NO**

- ☐ ☐ 1. Have you EVER had ANY licensing authority (INCLUDING MAINE) deny your application for any type of license, or take any disciplinary action against the license issued to you in that jurisdiction, including but not limited to warning, reprimand, fine, suspension, revocation, restrictions in permitted practice, probation with or without monitoring?
- ☐ ☐ 2. Have you EVER agreed with any licensing authority to voluntarily follow practice limitations, restrictions, guidelines, to make reports or to complete specific continuing education or course work?
- ☐ ☐ 3. Have you EVER been notified of the existence of allegations involving you, filed with or by ANY licensing authority (INCLUDING MAINE), which allegations remain open as of the date of this application?

**SINCE YOUR LAST RENEWAL APPLICATION:**

**YES NO**

- ☐ ☐ 4. Have you left a medical licensing jurisdiction (INCLUDING MAINE) while a complaint or allegation was pending?
- ☐ ☐ 5. Have you been denied registration, or had your ability to prescribe or dispense controlled substances modified, restricted, suspended, revoked, or voluntarily suspended by, or surrendered to
- ☐ ☐ a) U. S. Drug Enforcement Administration (DEA)?
- ☐ ☐ b) Any state/territory of U. S. INCLUDING MAINE?
- ☐ ☐ 6. Has there been a finding by any state or federal court or governmental agency that you violated any rule or law regulating the practice of health care?
- ☐ ☐ 7. Has there been a finding against you in any inquiry, investigation, or administrative or judicial proceeding by an employer, educational institution, professional organization, or licensing authority, or in connection with an employment disciplinary or termination procedure?
- ☐ ☐ 8. Have you received a sanction regarding Medicare or any state Medicaid program?
- ☐ ☐ 9. The purpose of the following questions is to determine the current fitness of the applicant to practice medicine. The following inquiries concern medical, mental health, and substance misuse issues. This information is treated confidentially by the Board. The mere fact of treatment for medical, mental health or substance misuse is not, in itself, a basis on which an applicant is ordinarily denied licensure when he/she has demonstrated personal responsibility and maturity in dealing with these issues. The Board encourages applicants who may benefit from such treatment to seek it. The Board may deny a license to applicants whose ability to function in the practice of medicine or whose behavior, judgment, and understanding is impaired by substance misuse or a medical or mental health condition.
- ☐ ☐ a. Do you have a mental or physical condition that currently impairs your ability to safely and competently practice medicine?

**SINCE YOUR LAST RENEWAL APPLICATION:**  
**YES NO**

- ☐ ☐ b. Have you been diagnosed with or treated for any medical or mental health disorder that impaired your behavior, judgment, understanding, or ability to function in school, work or other important life activities?
- ☐ ☐ c. Do you currently use any chemical substance(s), including alcohol, which in any way impairs or limits your ability to practice your profession with reasonable skill and safety?
- ☐ ☐ If any of your answers to questions 8(a-c) is "Yes," are the limitations or impairments caused by your medical, mental health, or substance misuse condition reduced or improved because you receive ongoing professional treatment (with or without medication) or because you participate in a professional monitoring program? Current voluntary participation in the Medical Professionals Health Program or similar program will be kept confidential?
- ☐ ☐ N/A
- ☐ ☐ d. Are you currently engaged in the illegal use of illicit drugs or prescription drugs that have not been prescribed to you pursuant to a legitimate physician-patient relationship? "Legitimate" means "Being in compliance with the law or in accordance with established and accepted standards."
- ☐ ☐ e. Have you used illegal drugs or prescription drugs that have not been prescribed to you pursuant to a legitimate physician-patient relationship?
- ☐ ☐ f. Have you used illegal drugs or prescription drugs that have not been prescribed to you pursuant to a legitimate physician-patient relationship?
- ☐ ☐ g. Have you furnished or provided illegal drugs to anyone other than medical marijuana per applicable state law?
- ☐ ☐ h. Have you furnished prescription drugs to or written a prescription for anyone without having a legitimate physician-patient relationship (This includes conduct for which you may NOT have been adjudicated in any civil, administrative or criminal proceeding)?
- ☐ ☐ i. Have you been found in any civil, administrative or criminal proceeding to have:
- ☐ ☐ a. Possessed, used, prescribed for use, or distributed any drugs in any way other than for legitimate or therapeutic purposes?
- ☐ ☐ b. Diverted any drugs?
- ☐ ☐ c. Violated any drug law?
- ☐ ☐ d. Prescribed any controlled substances for yourself or family/household members?
- ☐ ☐ j. Have you raised the issue of consumption of drugs or alcohol or the issue of a medical, mental health or substance misuse disorder as a defense or in mitigation of, or as an explanation for your actions in the course of any administrative or judicial proceeding or investigation; any inquiry or other proceeding; or any proposed termination action (educational, employer, government agency, professional organization, or licensing authority)?
- ☐ ☐ 10. Have you been charged, summonsed, indicted, arrested, or convicted of any criminal offense, including when those events have been deferred, set aside, dismissed, expunged or issued a stay of execution? Please include motor vehicle offenses such as Operating Under the Influence, but not minor traffic or parking violations.
- ☐ ☐ 11. Have you applied for hospital, HMO or other health care entity privileges which were denied?

- ☐ ☐ 12. Have you had your staff privileges or employment at any hospital, long term care facility, HMO, or other health care entity terminated, revoked, reduced, restricted in any way, suspended, made subject to probation, limited in any way, or withdrawn involuntarily?
- ☐ ☐ 13. Have you voluntarily surrendered privileges or resigned from staff membership during peer review or investigation or to avoid peer review or investigation?
- ☐ ☐ 14. Have you resigned from employment in lieu of termination or while under investigation?
- ☐ ☐ 15. Have you been terminated or suspended from any employment?
- ☐ ☐ 16. Have you been deselected from a managed care organization physician panel?
- ☐ ☐ 17. Have you been disciplined by a professional society or resigned while an accusation was pending?
- ☐ ☐ 18. Have you endangered the safety of others, breached fiduciary obligations, or violated workplace conduct rules?
- ☐ ☐ 19. Have you been named in any medical malpractice liability claim or lawsuit, including nuisance suits settled, adjudicated by a court in favor of the other party, or settled by your insurance company/representatives without your express consent?
- ☐ ☐ 20. Do you have any open/pending malpractice claims?
- ☐ ☐ 21. Do you intend to practice medicine within the State of Maine without active medical staff privileges at a Maine hospital?
- ☐ ☐ 22. Do you plan to practice telemedicine in Maine:
- ☐ ☐ a. From within the state?
- ☐ ☐ b. From within the state?
- ☐ ☐ c. Will you combine face to face practice and telemedicine?
- ☐ ☐ d. Will you practice only in conjunction with a state licensed physician?

# Maine Board of Licensure in Medicine

Professional (Malpractice) Liability Claims Experience

Duplicate For Multiple Claims.

See Instructions on Pages 1

My Name:

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Identity of Case:

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Date and Place of Original Occurrence:

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Malpractice Alleged By Claimant: Summary of My Defense:

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Current Status of Case (Include payment amounts:)

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Name and Address of Insurance Company and/or Attorney Defending the Case:

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